May 2015
Vol.10

Medication Safety Bulletin

The Medication Safety Bulletin (MSB) is published by the Medication Safety Committee HAHO(MSC) biannually (May and Nov) as an educational publication to share issues related to medication safety.

Please refer to the HA Risk Alert (HARA) for sharing of medication incident cases reported in HA.

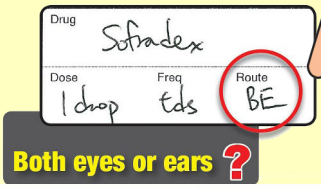
Inside this issue:

Update of HA Do Not Use List in Prescribing (2015)

The HA "Do Not Use" list was first announced in 2008 with respect to written prescription to help minimizing medication incidents related to the misinterpretation of prescription orders. The current version was updated in 2010, with two more items (Trailing zero and Omission of leading zero) added.

Based on overseas recommendation on the use of abbreviation and local incidents involving misinterpretation of abbreviation, there would be another update announcing in 2Q2015. This update will add several new items too, and will also update recommendations on existing Do Not Use abbreviations.

New Do Not Use abbreviations are listed as followings:



Do Not Use (Intended meaning)	Potential Problem	Use Instead
BE/LE/RE (Both/Left/Right EAR/EYE)	Confusion between Ear/Eye application sites	Prescribe in full term
N or (N) (Noon) N or (N) (Nocte)	Confusion in frequency with each other	Prescribe in full term "noon" Prescribe in full term "nocte"
IVI or V or (V) (Intravenous) IMI or M or (M) (Intramuscular)	Confusion in route of administration with each other	Prescribe in IV or I.V. Prescribe in IM or I.M.
HCT (Hydrocortisone) HCTZ (Hydrochlorothiazide)	Misinterpretation with each other	Prescribe in complete drug name

A **6-month grace period** is allowed for adopting **BE/LE/RE** as Do Not Use Abbreviations. Institutions may consider the use of pre-printed MAR designed for ear/eye preparations with choices of application sites readily available.

There is also an update of the "Do Not Use abbreviation" as below:

Do Not Use (Intended meaning)	Potential Problem	Use Instead
q.o.d, qod, Q.O.D., QOD (every other day)	Misinterpreted as qd (daily) or qid (four times daily)	every other day (Specify odd or even day dosages, if applicable)

The HA Do Not Use List is included as Appendix 2 of the HA Guidelines on Medication Management – Prescribing, Dispensing and Administration.

The above guidelines and other guidelines/recommendations issued by the MSC can also be accessed via below link:

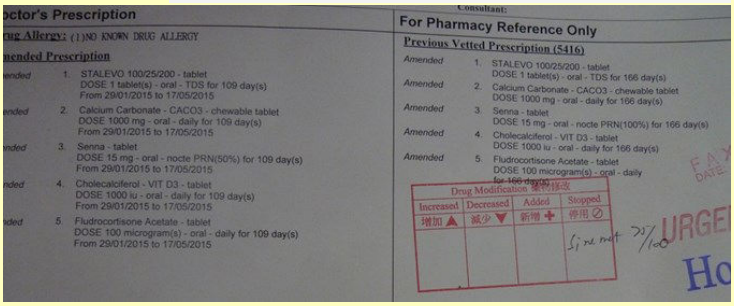
http://portal.home/sites/cpo/committees/msc/guidelines/default.aspx

Sharing of good practices from hospital visits by the Medication Safety Committee, HAHO

Good practices in Discharge prescription

Designated chop for prescriber to notify changes in discharge prescription

Couple with patient counselling to prevent administration of old regimen



Good practices in storage of Injectable Drugs

Drawers with each designated for storage of injectable drugs of one patient only

To minimize risk of mixing up medications of different patients

Ward A

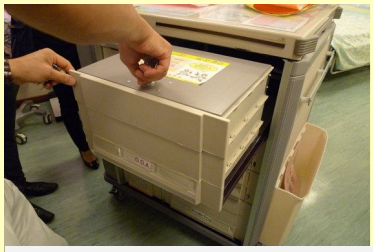
Ward B

Clear partitioning and clear labelling of different iv infusions

To minimize risk of mixing up preparations with similar appearance

Good practices in storage of Dangerous Drugs

Different units of the same institution can customize own practices of handling DD to suit operational need.



In a psychiatry ward, DDs were locked and stored inside drug cart; oral DDs are centrally administered to patients inside treatment room

To minimize missing/double dose , and minimize security issue due to higher mobility

In a palliative care ward, portable trolley (lockable inside cupboard) was used to store DDs

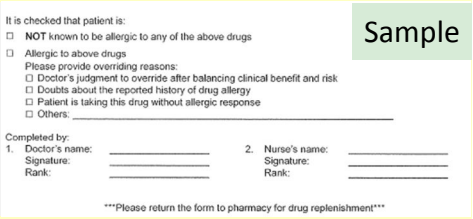
To facilitate bed-side administration

Good practices in Drug supply outside pharmacy service hours

For institutions without 24-hour pharmacy service, in case supply of medication is required outside pharmacy service hours, medication safety can be enhanced by proper documentation and facilitation of known drug allergy checking .

Checklist of known drug allergy to be signed by 1 doctor and 1 nurse

Cross-sensitivity information is also available for reference



Sample

It is checked that patient is:
- ☐ NOT known to be allergic to any of the above drugs
- ☐ Allergic to above drugs

Please provide overriding reasons:
- ☐ Doctor's judgment to override after balancing clinical benefit and risk
- ☐ Doubts about the reported history of drug allergy
- ☐ Patient is taking this drug without allergic response
- ☐ Others: _____

Completed by:
1. Doctor's name: _____ Signature: _____ Rank: _____
2. Nurse's name: _____ Signature: _____ Rank: _____

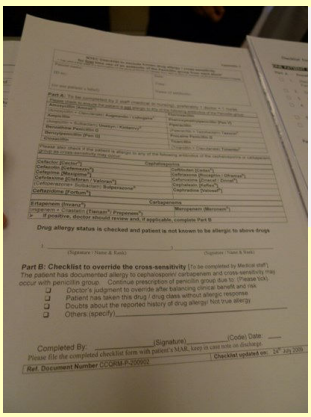
Please return the form to pharmacy for drug replenishment

Good practices in handling Drug return

Lockable cabinet for ward-return

Collected by pharmacy once or twice weekly; to prevent unintentional use of medication pending return

Good practices in Known Drug Allergy Checking



Checklist of known drug allergy for the first use of penicillin group medications

Counter-checked by 2 staff (At least one medical grade)

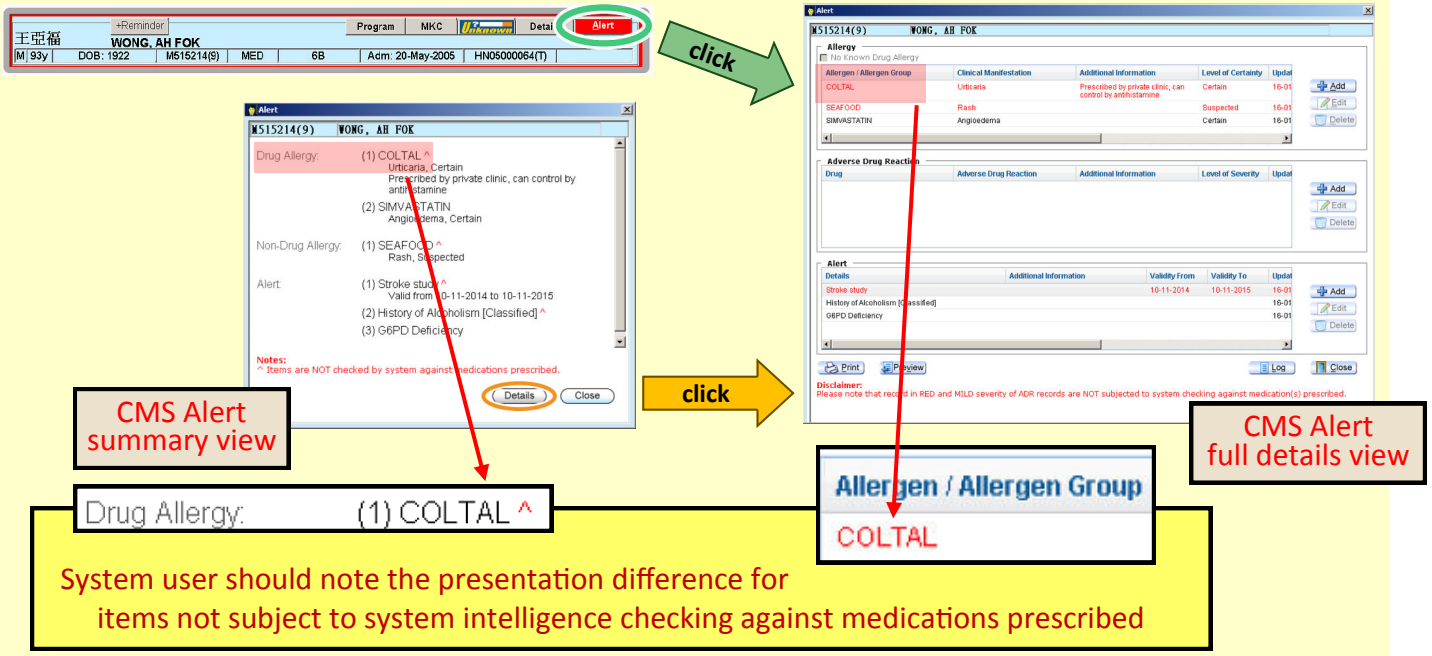
Eye-catching signs inside and outside drug drawers

For patients with known drug allergy and/or patients require crushing of oral medications

NEW function in Clinical Management System: CMS Alert Summary View

In order to facilitate clinical workflow and to enhance system performance, a new function of CMS alert summary view is rollout which **prompts automatically** instead of showing full version of alert.

When Details button on summary view or Alert button in patient object is clicked, the full version of alert will be shown with full details of Allergy/ADR/Alert available for reference. Other functions (e.g. editing known drug allergy record) remains unchanged.



MSC Project Summary (2014/15)

2Q2014
- Medication Safety Hospital Visit 3rd Round - NTEC (Shatin Hospital and Tai Po WSC GOPC)

- Medication Safety Bulletin vol. 8

3Q2014
- Update of Cross-allergy Reference Table (Appendix of HA Guideline on Known Drug Allergy Checking)

4Q2014
- Annual Medication Safety Forum 2014 **Role of Technology, Automation and Informatics in Medication Safety**

- Medication Safety Bulletin vol. 9

1Q2015
- Medication Safety Hospital Visit 4th Round - KEC (Tseung Kwan O Hospital and Tseung Kwan O Jockey Club Clinic)

Other completed projects in 2014/15:

- Review of Governance, Terms of Reference and membership of MSC
- Set up of Task Group on Conversion of free-text drug allergy record in CMS
- Review of HA Do Not Use List in Prescribing and measures on abbreviation management

Visit MSC's intranet page to know further details of MSC and HA's effort on enhancing medication safety:
http://portal.home/sites/cpo/committees/msc/default.aspx